Written comments submitted to the Department of Health Care Services (DHCS) Regarding the Transfer of Medi-Cal Related Specialty Mental Health Services to DHCS

Comments received August 31, 2011 through September 9, 2011

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Members of the California Association of Social Rehabilitation Agencies (CASRA), a statewide organization of private, not-for-profit, public benefit corporations that provide recovery-oriented services to clients of the California public mental health system, support the Department of Health Care Services (DHCS) draft transition plan for the transfer of Medi-Cal specialty mental health services from the Department of Mental Health (DMH) to DHCS effective July 1, 2012 and commend DHCS in meeting an ambitious timeline. We appreciate the opportunity to continue to be part of the planning process and believe that increased efficiencies and improved services can be achieved.

We've identified the following items as priorities at this time:

- **Page 4**: Emphasis of the transfer to "Improve access to culturally appropriate community-based mental health services, including a focus on client recovery, social rehabilitation services, and peer support." We are very pleased to see the explicit inclusion of social rehabilitation services. For over 40 years, CASRA has promoted the philosophy and principles of the social rehabilitation approach and was instrumental in establishing the Medicaid Rehabilitation option in California. We look forward to discussing specific strategies to increase the availability of these cost effective approaches in meeting the needs of Californians with serious mental health concerns.

- **Page 5**: As the tasks of the workgroups established by DHCS become less focused on technical issues and more centered on programmatic matters we encourage the active participation of stakeholders including mental health consumers.

- **Page 5**: We applaud the DHCS commitment to "utilize the expertise of DMH staff as well as numerous stakeholders at the local level." We believe that much will be gained from retaining seasoned DMH staff and involving local communities.

- **Page 11: Annual Certifications:** DMH certifies Community Residential Treatment Programs (CRT) that are licensed by the Department of Social Services (DSS) as Social Rehabilitation Facilities. This dual oversight is hugely problematic as the licensure regulations are often in direct conflict with the programmatic requirements for certification.

In a recent meeting with Health and Human Services Agency (HHS) Secretary Dooley's staff, we discussed a proposal to eliminate DSS/CCL licensure of these treatment programs and proposed an alternative. The proposal would combine the existing DMH CRTS programmatic certification with any other requirements that are part of the MediCal

certification process into a single regulatory package that would be housed at DHCS as the MediCal responsible entity. DHCS could choose to incorporate the capacity to license programs or be the responsible entity for developing statewide licensure standards that are delegated or contracted to the county.

- **Page 25:** We applaud the DHCS commitment to maintain the "identities and integrity" of DMH and the Department of Alcohol and Drug Programs (DADP). Measured consideration should guide any future integration. Given the less than enthusiastic response from the drug and alcohol community to the term "behavioral health" we like the alternative proposal for the department to mirror the federal title of the Substance Abuse and Mental Health Services Administration (SAMHSA).

- **Page 25:** In addition to "extensive knowledge and experience in the fields of mental health and substance use disorders" the new Deputy Director should have a thorough understanding and solid commitment to the goals, values and principles of a culture-centered approach to mental health recovery. Because of the importance of employment and stable housing in sustaining mental health recovery the new Deputy Director should have knowledge of the Department of Housing and Community Development and the Department of Rehabilitation (DoR) as well as a demonstrated ability to advocate for increased access to programs funded or operated by these Departments. DoR has a less than stellar track record of serving persons with psychiatric disabilities and this is a problem that needs to be addressed.

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CALIFORNIA MENTAL HEALTH DIRECTORS ASSOCIATION (CMHDA) COMMENTS ON THE DEPARTMENT OF HEALTH CARE SERVICES (DHCS) TRANSITION PLAN FOR MEDI-CAL SPECIALTY MENTAL HEALTH

The DHCS draft transition plan for Medi-Cal Specialty Mental Health is very comprehensive and readable, and lays out a realistic, staged timeframe for implementation. Additionally, the plan describes a significant stakeholder input and legislative update process that allows for adjustment during the implementation phase. Acknowledging the Assembly Bill 102 goals of increased access, efficient financing, accountability, and high-level leadership, the plan emphasizes that thoughtful change takes time, but that the transition must occur by June 30, 2012.

The California Mental Health Directors Association (CMHDA) is in full support of the goals established by the Legislature and those outlined in this draft transition plan. Listed below are comments on specific elements of the transition plan that we believe will improve the plan and assist the transition process.

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- The plan emphasizes the role of DHCS in the planning and implementation of the transition, from an internal state perspective with strong external stakeholder input. ***We recommend that DHCS include county mental health representation on the Project Management Team*** established by DHCS in recognition of the significant change in the counties' roles under 2011 Realignment. As the roles of state and local government will undergo significant change, there is clearly a need for a strong implementation partnership with local government.
- The plan provides an excellent summary of the current Medi-Cal mental health coverage and service array available in California. It also establishes a new Deputy of Behavioral Health position as a part of the DHCS executive management. ***We recommend that this new position have responsibility for the entire Medi-Cal mental health service array,*** including Specialty Mental Health, fee-for-service mental health, and new 1115 Demonstration Waiver, to promote the efficient integration of all elements of behavioral health coverage in California.
- The plan acknowledges the importance of stakeholder involvement and the need for ongoing stakeholder engagement. We fully support this goal and ***recommend that it include engaging stakeholders in a continuous quality improvement and results oriented process*** similar to that which was convened by DMH under the Statewide Quality Assurance Committee.
- The plan acknowledges that legal issues and court decisions impacting Medi-Cal Specialty Mental Health must be reviewed and coordinated from an internal state perspective. ***We recommend that the plan include the addition of county representation in this process, when appropriate,*** in acknowledgement of the important role of counties in implementation of legal decisions or settlements that require changes in service, financial, or compliance responsibilities.
- The plan outlines a list of proposed changes and efficiencies including regulatory review, improved business and finance practices, access and service improvements and stakeholder engagement. ***We strongly support adopting a short, medium and long term goals approach to addressing these opportunities for process improvements.*** Our recommended areas for initial focus include ***addressing access disparities, removing barriers to federal reimbursement and timely cost settlement, and continued collaborative efforts focused on aligning Medi-Cal mental health coverage with the principles of recovery, resiliency and evidence-based practice***.

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- In consideration of the pressing need to effectively and efficiently implement 2011 Realignment, ***we recommend that DHCS and county representatives establish a workgroup focused on implementation of improved business practices***. We recommend that initial priorities include ***improving Certified Public Expenditure (CPE) interim payment and settlement processes, integration of the supervision of cost report audit staff and procedures*** into existing DHCS units, and exploring all opportunities to ***maximize appropriate federal financial participation***.

We appreciate and commend the department's efforts to develop a comprehensive transition plan that is consistent with the Legislature's direction and has been enhanced by the stakeholder process that has been convened. We welcome the opportunity for continued input and the formation of a county-state partnership to efficiently implement the proposed changes both now and in the future.

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California Council of Community Mental Health Agencies (CCCMHA) Comments on Draft Plan to be submitted to Legislature by 10-1-11

As a draft plan that precedes the hiring of the Deputy Director to lead this new division, we accept that it is premature for the department to commit itself to specific policies. However, we believe that in this preliminary plan the department could acknowledge the importance of several issues and commit itself to establishing appropriate staff with adequate resources and support for committees comprised of state and local officials and other important stakeholders to develop options and recommendations to address each of the important issues we list below. There may not need to be separate committees for each subject but it is clear that there is not sufficient expertise within state government on any of these issues. It should be acknowledged that a necessary element is to create committees to work in partnership with mental health leaders in counties, provider agencies and client and family organizations.

1. **A Plan to meet all mental health and alcohol and drug needs by 2014.**

Everything that is done over the next three years by the state and counties must be in the context of moving from the drastically underfunded current mental health and alcohol and drug programs to fully funded programs in 2014.

The quantification of that need and the financial plan for addressing will come from the Centers for Medicare & Medicaid Services (CMS) required plan as part of the 1115 waiver. That document will rely on funding from the Medicaid Expansion and insurance mandate of the

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national Affordable Care Act. However, it won't be enough unless several other issues are addressed as several barriers stand in the way.

Besides putting a staffing structure in place to address these barriers, DHCS needs to have a plan that identifies who and how the staff and resources will be there to address all of these barriers. For many of the issues the role of DHCS must complement the role of the Mental Health Services Oversight and Accountability Commission (MHSOAC) in its oversight of the programs funded by the Mental Health Services Act (Proposition 63 of 2004 – MHSA)

2. Other Important Issues

Below are lists of some of the policy areas that require specific staff, resources to obtain expertise outside of state staff and a plan to achieve policy and fiscal objectives.

1. Paperwork and Compliance – Rethink Compliance in Realigned World
2. Prevention and Early Intervention (responsibilities of health plans and primary care) - Partnership with MHSOAC
3. Integration of physical health and mental health for people with severe mental illnesses
4. Underserved Communities and Cultural Competence- Partnership with MHSOAC
5. Discrimination and Stigma – Partnership with MHSOAC
6. Quality Improvement and Evaluation – Partnership with MHSOAC
7. Decision-making and Relationships with mental health stakeholders - Partnership with MHSOAC
8. Workforce (partnership with Mental Health Planning Council)
9. Peer Support
10. Recovery Model of Services
11. Co-Occurring Mental Health and Alcohol and Drug Disorders
12. MHSA – Memorandum of Understanding (MOU) with MHSOAC

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Detailed Analysis of Each Program Element

1. Paperwork – Rethink Compliance in Realigned World

An informal survey of Community mental health providers concluded that on average 40% of their funding goes to "paperwork" (which includes everything that is not direct services). In addition counties spend an additional 15% of funds on "administration" and there are state and other administrative costs that push the non direct service costs to nearly 60% of total funding.

A national expert on efficient community mental health…. [personal, identifying information removed]…., has worked with many states to reduce this burden through eliminating duplicative and inefficient approaches and has demonstrated that can and should get that total under 30% which for California could increase our levels of service by 50% at no cost.

Some of this is focused on providers developing ways to eliminate no shows. Others eliminate duplicative data entry and working with government agencies and providers to develop more efficient ways to collect information and to focus on what is really worth the effort.

California Department of Mental Health (DMH) has had a lot of its "compliance" efforts focused on ways to reduce state general fund costs of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program while the state had to bear 90% of the non federal share of costs. With that program scheduled to be realigned to counties that motivation should disappear. There should be a plan for the state to work with counties, providers and other stakeholders to minimize this paperwork burden (while retaining the data collection needed for compliance and for quality improvement as will be discussed below)

Some compliance is still required and it is envisioned that DHCS will be responsible for the performance contract (currently a DMH responsibility) to ensure that each year each county program and expenditure is in compliance with all applicable state and federal requirements. There is a need for structure for how staff will implement this requirement and ensure compliance in all expenditures – including MHSA expenditures which will be a significant part of how counties meet their Medi-Cal obligations.

2. Prevention and Early Intervention in Primary Care– Including Screening and mental health and Alcohol and Drug Co-located services

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Mental health and alcohol and drug problems can be identified through short questionnaires (such as the Patient Health Questionnaire [PHQ]-9) that patients or their parents complete to provide screening in primary care. Studies demonstrate the cost effectiveness of screening everyone who sees their primary care office and offering co-located modest mental health and alcohol and drug services for those whose screening reveals a need for services.

The public mental health system on its own is a "fail first" system with people not getting referred to that system until they have had a major failure in education, employment, homelessness, criminal justice or hospitalization.

These crises don't occur at the onset of a mental illness but only after the symptoms have been untreated for many years. These symptoms may be subtle and not easy for people to recognize as a sign of mental illness so people don't seek help and thus the screening questionnaires have been proven to be a necessary way to identify a mental illness early in its onset.

Primary care physicians cannot be expected to do this without financial incentives from health plans as the savings accrue mostly in hospitalizations (see County Medical Services Program (CMSP) pilot program and Lewin group study of that program which is now being expanded). However, health plans have been slow to implement these improvements. Accordingly this is an area where state leadership is needed and will be limited unless DHCS or the Legislature requires it of health plans. Articulating this need and proposing it as part of the plan is a necessary step towards meeting all mental health and alcohol and drug needs and reducing not only higher cost mental health program caseloads but reaping even greater savings in physical health inpatient costs.

3. Integration of Mental health and Physical Health for people with severe mental illnesses

The transition to managed care for people with disabilities creates a new opportunity for ensuring that the physical health needs of people with severe mental illness can get the attention that is long overdue. The national study of eight state Medicaid populations showed that people with severe mental illness died on average 25 years younger than others created an awareness of just how much of a crisis this problem is.

One of the great opportunities created by this part of the Section 1115 Waiver and this consolidation is to ensure that there is a medical home that is integrated with mental health care for each of these disabled people with a severe mental illness.

4. Underserved Communities and Cultural Competence

Latinos represent about 40% of MediCal enrollees but only about 10% of MediCal enrollees who access MediCal mental health services. Similar statistics affect many other cultures. The California Health Interview Survey data shows relatively similar prevalence of mental illness in all cultures but much more varying levels of accessing mental health services.

Moreover, when services are delivered the services won't be successful unless delivered in a manner that addresses the culture of the client and family being served.

These two issues combined require a special focus on multicultural services for mental health that is different than for other medical conditions and an office, plans, data collection and education to address these challenges.

5. Discrimination and Stigma

Mental illness is stigmatized in society with discrimination in housing, employment, education and in healthcare. If DHCS is the leading state agency in serving people enrolled in MediCal then it is responsible for the care and consequences for adults with severe mental illnesses and children with serious emotional disturbances who experience that discrimination and stigma and must support programs to address these problems and consequences. Moreover the stigma causes people to avoid seeking care for fear of the label and these delays in seeking care add to healthcare costs. There must be staff, resources and plans in partnership with counties, stakeholders and the MHSOAC to address these problems.

6. Quality Improvement and Evaluation

While the delivery of programs is the responsibility of counties, the state remains responsible to the federal government to ensure that all MediCal enrollees receive all medically necessary services in the least restrictive environment. Accordingly the state must ensure that all counties have adequate resources to meet this obligation and that they are using available resources efficiently. The performance of counties and providers must be compared to measure relative results of care and efficiency to ensure that limited resources are being used as effectively as possible and to partner with counties and providers to identify the best practices.

The MHSOAC is taking the lead in developing the evaluation tools necessary to identify best practices and educate others to improve overall quality and efficiency among providers of services. There must be a partnership between DHCS and the MHSOAC to develop the data collection, reporting and evaluation needed both for quality improvement and for compliance.

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7. Decisionmaking and Relationships with mental health stakeholders

The mental health services act requires that the perspective of clients and families with severe mental illness must be considered in all policy and fiscal decisions. This requires a consensus oriented collaborative process in making ALL state decisions affecting these populations – nearly all of whom will be MediCal recipients by 2014. This type of process has been begun by the DMH but has not been followed consistently. An office staffed with clients and family members and a plan and set of regulations to ensure that such a process is consistently followed should be adopted and implemented in partnership with the MHSOAC.

8. Workforce – (Partnership with Mental Health Planning Council)

As we increase mental health and alcohol and drug services there will be a need for a dramatic expansion in the number of people working in these fields and we need to have plans and programs to attract and retain the workers we need. This is a special focus of the Mental Health Services Act. Implementation of this part of the act is led by the Mental Health Planning Council and DHCS strategies should be coordinated with the planning council.

9. Peer Support

The workforce plan must reflect the value of lived experience in the workforce meaning that a significant portion of the staffing should be individuals and families who have experienced severe mental illness. While partially addressed by a recent state plan amendment (SPA), most states have gone further in amending their plan to ease the direct billing for these services and this must be addressed in a future SPA.

10. Recovery Model of Services

Most of the services for people with severe mental illness are recovery model services and the needs analysis must reflect the staffing needs built around the most successful programs utilizing that model as demonstrated through comparative evaluation efforts.

11. Co-Occurring Mental Health and Alcohol and Drug Disorders

Co-Occurring Mental Health and Alcohol and Drug Disorders should be the expectation not the exception. Much of the staffing and structure of the new division of DHCS may have separate elements for mental health and alcohol and drug services. However, about half of

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the people who have mental illness or alcohol and drug dependence also have the other condition. Given the current and historical differences in structure, funding and services, there must be a plan for more integrated care and staff that supports the expansion of integrated care programs and policies.

12. Mental Health Services Act (MHSA)

Many parts of this paper refer to the need for partnership with the MHSOAC. Beyond those specific details is the need for state staff that is looking at how to best use those funds to achieve the primary goal of making sure that all MediCal enrollees are receiving all medically necessary services and the related goals of getting the best results from those services in the least costly and least restrictive manner feasible.

DHCS needs to have staff, resources to obtain outside experts, and a plan for how to implement the MHSA for MediCal enrollees and an MOU that delineates what DHCS is responsible for, what the MHSOAC is responsible for and what will be the responsibilities of other offices and departments.

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This letter provides comment on the Draft Transition Plan of Medi-Cal Related Specialty Mental Health Services from the Department of Mental Health (DMH) to the Department of Health Care Services (DHCS) effective July 1, 2012.

The primary concern of the Fresno County Department of Social Services is the ability to obtain essential mental health, preventative mental health and supportive mental health services for the adults, children and families who are affected by mental illnesses and who are involved within our service systems.

The County continues to suffer from the inability to secure sufficient Psychiatrists to serve our families. Many of the children who are involved in the Child Welfare system will need to receive continued home, community-based and school-based services which are located within the Fresno County area. Most important is the financial support in order to insure the availability of these services within our local county areas which are both urban and rural. With this preface statement, our comments on the Draft Transition Plan are as follows:

Page 18 Item 5. This department supports the stakeholder recommendations to have fully executed, current, approved contracts between the State and County Mental Health Providers (MHP), and to expand covered services to include the use of peer support within its service components.

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Page 19 Items 10, 11, 12 and 15. As new laws affect the funding for health, mental health, social services and safety; it is imperative that the Realignment of funding not result in detrimental treatment of our needy citizens. It is requested that DHCS continue to respect the current needs within local communities and programs through fiscal avenues and claiming processes. Additionally it is important to include local county comments on fiscal and programmatic changes that are proposed by DHCS, and to budget the travel expense necessary to attend the events and meetings. Please make available through public means, the names, titles and phone numbers of assigned staff with their corresponding functions so that counties may easily access the individuals necessary.

Page 21 Items 21, 22 and 24. Incorporate that the State will provide the counties and concerned citizens with timely notification of changes and an opportunity to comment on the Medicaid State Plan, Specialty Mental Health Services Consolidation, and other areas to be changed such as the cultural competency requirements.

Pages 22 and 23, Improve Business Practices. This department supports DHCS's plan to improve the business practices and eliminating any redundant reviews, reports and/or audits within its programs.

Page 27, Working with Stakeholders after the Transition is Underway. This department is appreciative of the work undertaken by DHCS to travel to the various areas of the state to collect input on the issues as seen within those communities. It is hoped these same processes can occur with future regulation and programmatic changes as outlined in the Draft Plan.

It is hoped these comments and recommendations will be incorporated into the department's practices and future endeavors to improve the health and mental health systems by integrating County, community organization and citizen input into its plans and practices.